

AUTHORIZATION TO DISCLOSE INFORMATION TO LEGAL AID OF WEST VIRGINIA (LAWV)

form created 4/9/03 slb

Please read the entire form before signing below.

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

All my medical records; also education records and other information related to my ability to perform tasks. This includes specific information to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including but not limited to:

(initial) Psychological, psychiatric or other mental impairment(s) including the notes written about me by my doctors and the notes written about me by my therapists, initial assessments(intake), comprehensive psychiatric evaluation; laboratory reports, social history, ninety (90) day re-evaluation; discharge/termination summary, treatment plan, psychological evaluation, and medication information

(initial) **Drug abuse, alcoholism, or other substance abuse**

(initial) **Sickle cell anemia**

(initial) **Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases**

➤ **Information about how my impairment(s) affect my ability to complete tasks and activities of daily living, and affects my ability to work.**

➤ **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**

➤ **Information created within twelve (12) months after the date this authorization is signed, as well as past information.**

FROM WHOM

• **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) Including mental health, correctional, addition treatment, and VA health care facilities

• All education sources (schools, teachers, records administrators, counselors, etc.)

• Social workers/rehabilitation counselors

• Consulting examiners used by Legal Aid of WV (LAWV) and/or Social Security Administration (SSA)

• Employers

• Others who may know about my condition (family, neighbors, friends, public officials)

TO WHOM Legal Aid of West Virginia (LAWV) is authorized to process my case, including contract copy services, and doctors or other professionals consulted during the process.

(initial)

PURPOSE Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet the Social Security Administrations definition of disability; and whether I can manage such benefits.

EXPIRES WHEN This authorization is good for twelve (12) months from the date signed (below my signature).

• I understand that I may write to Legal Aid of West Virginia (LAWV) and revoke this authorization at any time.

• I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

• I understand that there are some circumstances where this information may be redisclosed to other parties.

• Legal Aid of West Virginia (LAWV) will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.

• I have read this form and agree to the disclosures above from the types of sources listed.

I am specifically requesting records from the following health care provider: _____

INDIVIDUAL authorizing disclosure

(seal): Signed in the Presence of a Notary

Signature

Date Signed

Address: _____

Telephone Number: (_____) _____ -

Birthday _____

SSN _____

Print Full Name _____

Notary's
signature

Date